Council of New South Wales

Pharmacy Council of New South Wales

6th Floor, 477 Pitt Street SYDNEY NSW 2000
Postal Address: Locked Bag 20 HAYMARKET NSW 1238
Telephone: (02) 1300 197 177 Website: www.pharmacycouncil.nsw.gov.au

Application for NEW PHARMACY

Application and Inspection fee: $855.65

To be completed when establishing a new pharmacy with or without a professional services room.

This application should be completed with reference to **'The Guide,'** the *Health Practitioner Regulation National Law (NSW)* ('the Law') and the *Health Practitioner Regulation (NSW) Regulation 2010* ('the Regulation').

An application for a New Pharmacy must be lodged with the Pharmacy Council of New South Wales ('the Council') at least **14 days <u>before</u>** the intended opening date. This application may not be considered until all documentation is received. All documentation must be received by the **lodgement date** for the application to be considered at the next Council Meeting. The lodgement dates can be found on the Council website.

PHARMACY DETAILS TO BE REGISTERED

Pharmacy Name _____

Street Address _____

_____ Postcode _____

Telephone ( ) _____ Facsimile ( ) _____

Email _____

Postal Address _____

_____ Postcode _____

CONTACT FOR THIS APPLICATION

Name _____

Email _____ Tel _____

1. PHARMACY OWNERSHIP DETAILS TO BE REGISTERED

The Law permits an individual pharmacist to have a pecuniary interest in up to **FIVE** pharmacies. A pharmacist may **NOT** enter into a business arrangement exercising control over a pharmacy, with a non-pharmacist or a company, other than a pharmacists' partnership, Pharmacists' Body Corporate or Friendly Society [See Guide Note 6 'Pre-existing Non-pharmacist Ownership Structures').

1.1 Is the pharmacy to be owned by a:

- Sole pharmacist ☐ (Go to 1.2)
- Partnership of pharmacists ☐ (Go to 1.3)
- Pharmacists' Body Corporate ☐ (Go to 1.4)

*Where the proposed ownership structure involves a combination of the above, please complete 1.2, 1.3 and/or 1.4 as applicable and attach a separate schedule summarising the proposed structure.

1.2 Sole pharmacist

Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes ☐ No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

1.3 Partnership of pharmacists

Number of pharmacists in the partnership _____
(Partnership Agreement to be attached see 8 - 'Document Schedule')

*If more than six pharmacists please attach a separate schedule.

Pharmacist 1:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes ☐ No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 2:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes ☐ No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 3:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes ☐
No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 4:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes ☐
No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 5:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes ☐
No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 6:
Full Name _____ PHA _____

Do you have an interest in other pharmacies in NSW? Yes ☐
No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

1.4 Pharmacists' Body Corporate/s

Number of Pharmacists' Body Corporates _____

*if more than one Pharmacists' Body Corporate, please attach a separate schedule (1.4 to 1.9) for each.

Pharmacists' Body Corporate details

Registered name of Corporation _____
(ASIC Certificate of Registration and Company Extract must be attached, see 8 - 'Document Schedule')

ACN _____

Total number of members (directors/shareholders) in the Pharmacists' Body Corporate ____

All directors & shareholders of the Pharmacists' Body Corporate are to complete details.

Pharmacist 1:
Full Name _____ PHA _____

Director ☐ Shareholder ☐ (please tick)

Do you have an interest in other pharmacies in NSW? Yes ☐

No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 2:
Full Name _____ PHA _____

Director ☐ Shareholder ☐ (please tick)

Do you have an interest in other pharmacies in NSW? Yes ☐

No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 3:
Full Name _____ PHA _____

Director ☐ Shareholder ☐ (please tick)

Do you have an interest in other pharmacies in NSW? Yes ☐

No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 4:
Full Name _____ PHA _____

Director ☐ Shareholder ☐ (please tick)

Do you have an interest in other pharmacies in NSW? Yes ☐

No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 5:
Full Name _____ PHA _____

Director ☐ Shareholder ☐ (please tick)

Do you have an interest in other pharmacies in NSW? Yes ☐

No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacist 6:
Full Name _____ PHA _____

Director ☐ Shareholder ☐ (please tick)

Do you have an interest in other pharmacies in NSW? Yes ☐

No ☐

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

Pharmacy Name _____ Registration No. PC _____

1.5 Pharmacist appointed to be responsible for compliance with display of owner's name and display of drug prices in accordance with the *Price Information Code of Practice.*
[NB: Only applicable to exempted Body Corporates' and Friendly Societies, see Guide Note 6 - Pre-existing Non Pharmacist Ownership structures]

Full Name _____ PHA _____

1.6 Does the Pharmacists' Body Corporate act as a trustee of any Trust?

Yes ☐
No ☐ (Go to 2)

1.7 What is the name of the Trust?

_____
(Trust Deed must be attached, see 8 - 'Document Schedule')

1.8 Who are the beneficiaries of the Trust?
(All must hold General Registration)

Pharmacist 1:
Full Name _____ PHA _____

Pharmacist 2:
Full Name _____ PHA _____

Pharmacist 3:
Full Name _____ PHA _____

Pharmacist 4:
Full Name _____ PHA _____

Pharmacist 5:
Full Name _____ PHA _____

Pharmacist 6:
Full Name _____ PHA _____

1.9 The trust deed will be reviewed for compliance with the Law. If the trust is deemed non-compliant and a Trust Certification Checklist and Schedule of Amendments is required, you will incur a fee for the drafting of the Trust Certification Checklist and Schedule of Amendments. The fee will vary according to the complexity of the arrangements and the number of trusts involved and will be in the vicinity of $1600.00 plus GST per trust deed. [See Guide Note 4 - Trusts]

I/we acknowledge that the Trust deed will be reviewed and may, if deemed non-compliant, require the drafting of the Trust Certification Checklist and Schedule of Amendments. Should this occur, I/we undertake to meet the cost of the drafting of the Trust Certification Checklist and Schedule of Amendments on issue of an invoice from the Council.

_____ _____
Signed on behalf of the Pharmacists' Body Corporate Please print full name

2. ESTABLISHMENT DETAILS

The Law and the Regulation allows the Council access to relevant documentation for the purchase of a pharmacy. This section requires the disclosure of prescribed documents detailing the financial and other arrangements for the conduct of the pharmacy business.

2.1 Details of Finance/ Contributions
[see Guide Note 7 'Financial Arrangements']
(Loan/Finance Agreement & Statutory Declaration (if applicable) must be attached, see 8 - 'Document Schedule')

Pharmacist 1:
Personal Contribution* $ _____

Name of Finance Lender _____ $ _____

Pharmacist 2:
Personal Contribution* $ _____

Name of Finance Lender _____ $ _____

Pharmacist 3:
Personal Contribution* $ _____

Name of Finance Lender _____ $ _____

Pharmacist 4:
Personal Contribution* $ _____

Name of Finance Lender _____ $ _____

Pharmacist 5:
Personal Contribution* $ _____

Name of Finance Lender _____ $ _____

Pharmacist 6:
Personal Contribution* $ _____

Name of Finance Lender _____ $ _____

Total Finance **$ _____**

*Every pharmacist with a personal contribution must attach a completed Statutory Declaration (Annexure A)
[see Guide Note 7 'Financial Arrangements' for information about completing the Statutory Declaration]

3. DETAILS OF LEASE OF PREMISES

[Lease agreement of premises/transfer of lease document must be attached, see 8 - 'Document Schedule']

3.1 Will the pharmacy premises be leased? Yes ☐ No ☐ (Go to 3.8)

3.2 Is this a new lease? Yes ☐ No ☐

3.3 Is this a transfer of an existing lease? Yes ☐ No ☐

3.4 Is the lease a sub-lease? Yes ☐ No ☐
[see Guide Note 8 'Lease of Premises']

3.5 Complete the following details:

Head Lessor Name _____

Lessor Name (sub-lease) _____

Lessee Name(s) _____

_____

_____

3.6 What is the expiry date of this lease? _____

3.7 Does the lease have a percentage of turnover clause? Yes ☐ No ☐
[see Guide Note 8 'Lease of Premises']

Note: Any provision or clause in a lease agreement which provides that the lessor is to receive money, or other consideration, that varies according to the turnover of the pharmacy, is **void**.

3.8 Other arrangement (please specify) _____

_____

_____

4. PROFESSIONAL SERVICES ROOM

Are you intending to establish a Professional Services Room associated with this pharmacy?
[Professional Service Rooms are approved premises associated with, but separate to, the pharmacy and are limited to preparation and packaging, see Guide Note 9 'Professional Services Room Requirements']

Yes* ☐
No ☐

*If **yes** please also attach an Application for Professional Services Room.

5. SERVICE ENTITIES

5.1 Will a Service Entity be operating in association with this pharmacy?
[See Guide Note 5 'Service Entities']

Yes ☐
No ☐ (Go to 6)

5.2 Service Entity name _____

ABN _____ ACN _____

5.3 What form is this Service Entity?
(e.g. Trust, Service Company etc) _____

5.4 If a Trust, what is the name of the Trust? _____
(Copy of Trust Deed is **not** required)

5.5 Is there a Service Agreement? Yes* ☐
No ☐

(*If **yes** attach Service Agreement, see 8- 'Document Schedule')

6. FRANCHISE / BANNER GROUP

6.1 Is this pharmacy to be part of a franchise or banner group?

Yes* ☐
No ☐ (Go to 7)

(*If **yes** attach Franchise or Banner Group Agreement, see 8 - 'Document Schedule')

6.2 Will this arrangement involve a Licence Agreement or Management Services Agreement?

Yes* ☐
No ☐

(*If **yes** attach Licence Agreement or Management Services Agreement, see 8 - 'Document Schedule')

7. PHARMACY PREMISES REQUIREMENTS

[See Guide Note 9- 'Sketch Plan & Pharmacy Premises Requirements']

7.1 Check list of all equipment

[ ] Dispensing Balance
[ ] Funnel
[ ] Mortar and Pestle (2) (*at least 1 to be of glass*)
[ ] Spatulas (2)
[ ] Tablet Counting Tray
[ ] Ointment Slab
[ ] Refrigerator suitable for the storage of vaccines
[ ] Dispensary Barcode scanner for each dispensing station
[ ] Heavy Duty Scales
[ ] Dispensing Measure 200ml
[ ] Dispensing Measure 100ml
[ ] Dispensing Measure 10ml
[ ] Dispensing Measure 5ml
[ ] Stirring Rod
[ ] Heating facility

The Council expects that balances, scales, weights and measures will be stamped as approved under the *National Measurement Act 1960*.

7.2 Latest edition of the following publications:

[ ] *Health Practitioner Regulation National Law (NSW)*
[ ] *Health Practitioner Regulation (New South Wales) Regulation 2010*
[ ] *Poisons and Therapeutic Goods Act 1966* and *Regulation*
[ ] Martindale **or** AusDI **or** Micromedex **or** Therapeutic Guidelines
[ ] Australian Pharmaceutical Formulary and Handbook (APF)
[ ] Mims Annual **or** AusDI **or** Drugs on Disk
[ ] Pharmacy Guild Guide to the *NSW Poisons Schedules* **or** *NSW Poisons List*
[ ] Australian Medicines Handbook (AMH) **or** complete set of Pharmacy Self Care Cards
[ ] Price Information Code of Practice.

7.3 The Regulation requires a minimum size for the dispensary as well as requirements for equipment and access. Please complete the following:

Dispensary Floor area [square metres] Minimum 8 square metres

Dispensary Bench area [square metres] Minimum 1 square metre

7.4 It is important that a simple sketch plan (1:100) be supplied, either as an attachment, or drawn. If space is insufficient, attach a plan. The items listed in the Guide Note 9, 'Sketch Plan Information' should be highlighted.

Please ensure the following are marked on the sketch plan:

1. Direct public access ☐
2. Sink with hot and cold running water ☐
3. Confidential counselling area ☐
4. Dispensary barcode scanner(s) ☐

PHARMACY SKETCH PLAN ON THIS PAGE

8. DOCUMENTS REQUIRED

The Law permits the Council to request copies of any documents in support of this application. All relevant documents in the schedule below are to be lodged together with this application.

Any unsigned documentation will not be accepted.

DOCUMENT SCHEDULE

	(Please tick)	
	Document Attached	**Not Applicable**
Summary of Ownership Structure	☐	☐
Partnership Agreement	☐	☐
ASIC Certificate of Registration	☐	☐
ASIC Company Extract	☐	☐
Trust Deed	☐	☐
Loan/Finance Agreement	☐	☐
Statutory Declaration (Annexure A)	☐	☐
Lease agreement of premises/Transfer of lease	☐	☐
Service Agreement	☐	☐
Franchise/Banner Group Agreement	☐	☐
Licence/Management Services Agreement	☐	☐
Pharmacy Sketch Plan	☐	

9. CONSIDERATION OF APPLICATION, APPROVAL AND INSPECTION BY COUNCIL

[See Guide Note 17- 'Inspections by the Council']

9.1 The Council is unable to approve any premises that are within or partly within, or connected to, a supermarket and that the public can directly access from within the premises of the supermarket.

All Applications are subject to Council approval. Completed Applications will be considered at the next monthly Council Meeting. The Council Secretariat can be telephoned **after 11am on the day following** the meeting in order to find out the outcome of the application. Correspondence in respect of approvals will be mailed within **10 working days** of the Council Meeting.

Note: Following confirmation of approval, it is the applicant's responsibility to notify Medicare Australia.

9.2 Any approval by the Council is subject to a satisfactory inspection of premises. The date of registration of the pharmacy is deemed to be the date of satisfactory inspection.

Note: The application fee includes a fee for inspection of the premises. The inspection of premises must occur within 3 months of the lodgement of this application, on a date agreed upon by you and the Council Inspector. If the premises are not ready for inspection by the agreed date, you must provide the Council with a **minimum of 48 hours notice**. Cancellation within 48 hours, or premises requiring an additional inspection, will incur the full fee of $320.85 for each additional inspection.

On approximately what date can the pharmacy be inspected?

_____ (Please insert date(s))

Who can provide access for the Inspector?

Name _____

Phone (Tel) _____ (Mob) _____

Email _____

9. SIGNATURES AND DECLARATIONS BY ALL PARTIES

ALL PHARMACISTS TO SIGN

The following signatures are a declaration by the pharmacist(s) holding a pecuniary interest in the associated pharmacy that the information provided is correct and complete. The provision of information you know to be incorrect or incomplete may constitute unsatisfactory professional conduct.

If more than six partners / members of a Pharmacists' Body Corporate, please attach a separate schedule.

Pharmacist 1:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 2:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 3:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 4:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 5:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Pharmacist 6:
Full Name _____ PHA _____

Signature _____ Date _____

Witness:
Full Name _____

Signature _____ Date _____

Application for New Pharmacy Payment

Under Division 81 of the Goods and Services Tax Regulation, the Treasurer has determined that the above application fee is exempt from the Goods and Services Tax (GST).

Application fee: $534.80
Inspection fee: $320.85

Total: $855.65

Cheque ☐ Made payable to the ***Pharmacy Council of New South Wales***
Credit Card ☐ Complete details below

Name on the card _____

Cardholder's signature _____

Visa ☐ MasterCard ☐

Card Number

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry date ___/___ Amount $855.65 Date _____

We accept Visa or MasterCard only.

Annexure A

Statutory Declaration

OATHS ACT 1900, NSW, NINTH SCHEDULE

I, ……. , of …….
[name of declarant] *[residence]*

do hereby solemnly declare and affirm that ……

……

……

……

……

……

……

……

……

……

……

……

[*the facts to be stated according to the declarant's knowledge, belief, or information, severally*]

And I make this solemn declaration, as to the matter (or matters) aforesaid, according to the law in this behalf made – and subject to the punishment by law provided for any wilfully false statement in any such declaration.

Declared at: ……. on . . . . ……
[place] *[date]*

……
[signature of declarant]

in the presence of an authorised witness, who states:

I, ……., a ……,
[name of authorised witness] *[qualification of authorised witness]*

certify the following matters concerning the making of this statutory declaration by the person who made it: *[* please cross out any text that does not apply]*

1. *I saw the face of the person *OR* *I did not see the face of the person because the person was wearing a face covering, but I am satisfied that the person had a special justification for not removing the covering, and

2. *I have known the person for at least 12 months *OR* *I have confirmed the person's identity using an identification document and the document I relied on was ……
[*describe identification document relied on]*

……. ……
[signature of authorised witness] *[date]*